



	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. Royal Cornwall Hospital NHS Trust2. Cornwall Partnership NHS Foundation Trust3. University Hospitals Plymouth NHS Trust
1	<p>CORONER</p> <p>I am Assistant Coroner Stephen Covell, Assistant Coroner for Cornwall & the Isles of Scilly.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 21 April 2023 an investigation was commenced into the death of Norma Ann Patricia Tellam. I concluded the investigation at the end of the inquest on 8 April 2024. The conclusion of the inquest was Accidental Death. The cause of death was;</p> <ol style="list-style-type: none">1a Upper Gastro Intestinal Haemorrhage1b Proximal Femoral Fracture (operated)1c Fall
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On 22 January 2023 Norma Ann Patricia Tellam suffered an unwitnessed fall near her home sustaining a left proximal femoral fracture. On 23 January 2023 Mrs Tellam underwent surgery at the Royal Cornwall Hospital Truro to repair the fracture using a femoral intramedullary nail together with additional metalwork to stabilise and strengthen the repair. On 1 February 2023 Mrs Tellam was transferred to Liskeard Community Hospital for further rehabilitation with a planned review by the orthopaedic department at the Royal Cornwall Hospital within 6 weeks.</p> <p>On 4 February 2023 clinical staff became concerned that Mrs Tellam surgical hip wound</p>

might be infected. Mrs Tellam was sent to the emergency department at Derriford Hospital University Hospitals Plymouth rather than to the Royal Cornwall Hospital where the original operation was carried out. Mrs Tellam was returned to Liskeard hospital on 5 February 2023 after an infection was discounted.

On 10 February 2023 Mrs Tellam was sent again to Derriford Hospital with symptoms of a suspected infection. A chest infection was subsequently diagnosed and Mrs Tellam was admitted to Derriford Hospital where she remained until 21 February 2023 having subsequently developed Covid. On 11 February 2023 whilst Mrs Tellam was at Derriford Hospital her hip was x-rayed and reviewed by an orthopaedic consultant who identified some movement in the metalwork from the operation particularly a nail in the femoral head. He anticipated that Mrs Tellam would need to have some extra surgery and that she would be transferred back to the Royal Cornwall Hospital in Truro, where the original operation had been carried out and under whose care she remained, as soon as her chest infection resolved.

Mrs Tellam was returned to Liskeard Community Hospital on 21 February 2023 where attempts were made to rehabilitate her and improve her mobility. In the light of issues highlighted by the x-rays taken at Derriford, it would have been good practice to return Mrs Tellam to the Royal Cornwall Hospital for follow up.

Mrs Tellam continued to experience significant levels of pain from the hip joint and was x-rayed at Liskeard on 16 March 2023.. The x-ray identified that the nail in the femoral head had moved further and was now protruding into the hip socket. It is likely that the movement was caused by the rehabilitation.

The x-ray was discussed with the orthopaedic team at Royal Cornwall Hospital. Mrs Tellam was re-admitted to Royal Cornwall Hospital from Liskeard Community Hospital where she underwent on 23 March 2023 a operation to remove the metalwork from the original operation and subsequent total hip replacement.



Mrs Tellam initially made satisfactory progress after the operation however on 16 April 2023 she became very unwell suffering an upper gastro intestinal bleed and died at 0630 on 16 April 2023. It is likely that the bleed was caused by necessary anti-inflammatory and pain killing medication.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

- 5 1. Although Mrs Tellam was under the care of Royal Cornwall Hospital and awaiting a post operation follow up, when clinical staff at Liskeard Community Hospital had concerns about a possible infection at the site of the surgery Mrs Tellam was taken to Derriford Hospital rather than to the orthopaedic team at the Royal Cornwall Hospital who had recently operated on her.
2. When Mrs Tellam had recovered from a chest infection she was transferred from Derriford to Liskeard Community Hospital for further rehabilitation rather than to the Royal Cornwall Hospital for follow up on the developing problems with the fixing metalwork at the site of the hip surgery.
3. Decisions relating to the transfer of Mrs Tellam between Liskeard Community Hospital and Derriford Hospital did not give sufficient weight to continuity of clinical care.

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe your healthcare trust has the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 27th January 2025. I, the coroner, may extend the period.</p> <p>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons;</p> <p></p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.</p>
9	<p>2 December 2024</p> <p>Signature </p> <p>Stephen Covell Assistant Coroner for Cornwall and the Isles of Scilly</p>